NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Exhibit C: Instructions and AGO Questions for Written Testimony
June 17, 2011

1. If you are reimbursed through a contract that establishes a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only"), please explain and submit supporting documents that show how you quantify, analyze, and project your potential exposure to deficits and/or opportunities for surpluses.

New England Quality Care Alliance is a network of approximately 1,500 physicians throughout Eastern Massachusetts providing care to more than 500,000 patients. NEQCA serves as the platform for system integration, connecting an academic medical center, Tufts Medical Center, with community hospitals and community physician practices. The goal of NEQCA is to create a comprehensive clinically integrated system that can deliver, direct and create access to patient-centered healthcare in a cost effective, high quality manner. NEQCA provides this platform by providing the resources needed for an integrated system, such as electronic health records, data reporting and analysis, collaboration and alignment of incentives practice culture and delivery tools to drive comprehensive patient focused care. New England Quality Care Alliance has been a participant in Blue Cross Blue Shield's Alternative Quality Contract since 2009, and has had previous experience in risk based payment arrangements. 37 percent of NEQCA's commercial business is in the AQC, accounting for more than 93,000 lives.

In quantifying and analyzing the potential exposure for the network in a risk agreement, it is absolutely essential for a provider to have access to complete claims data, including information about the actual dollar amounts paid by the heath plan for those claims, for the patients served by provider. When NEQCA evaluated its ability to take on risk in 2009, a subset of its network had already been engaged in a risk contract with BCBSMA, which allowed NEQCA to have access to detailed claims data retroactive for 3-5 years for a subset of the lives served by the NEQCA network. NEQCA then requested from BCBSMA, and received, two years of detailed retrospective claims data for the entire network – and then compared our own actual claims data with a larger population data set supplied by an external firm.

It is critical for us to be able to identify where and how our providers will be able to generate change and impact the previous trend to reduce the cost trend. We must create a set framework to predict the potential losses and rewards for the risks that will be assumed. We must also consider and understand, to the best extent possible, the probability of an extreme loss versus a gain in any given year during the fixed timeframe of the agreement. We also must determine our ability to bear the deficit of any potential loss. We consider all of the factors that could create that loss and objectively analyze our ability to mitigate those detracting factors. This requires a sometimes unprecedented request for timely data from payers to provide robust claims data for a significant retroactive time period.

In the AQC, NEQCA and its physicians face a constant pressure to meet high quality measures and reduce the cost trend. One of the major components in driving the cost trend down and meeting the quality goals is to ensure that care is directed to high-quality, lower-cost providers in the market. NEQCA utilizes patient data and in-depth analysis to constantly work with our physicians to understand any trends and make real-time, evidence based, care management decisions. Health plans do not currently share overall health status adjusted network costs and other groups' costs, information that is critical for transparent comparison of costs among networks and identification of areas for continued improvement.

2. Please explain and submit supporting documents that show your internal analysis of your ability to manage any risk you currently bear related to your contracts with commercial insurers, including the per member per month costs associated with bearing risk (risk management costs, staffing, reserves, and stop-loss coverage), projections of deficit scenarios, solvency standards, contingency plans in the event that you run a deficit, or any similar analysis. Please include any analysis you have conducted on how much your costs and risk-capital needs would change based on increases or decreases in risk you bear in relation to your business with commercial insurers. In addition, please explain the type of data that you currently utilize, or would like to utilize, to manage your performance under a risk budget.

Currently, the risk and potential reward in a contract with a commercial health insurance payer is the result of a negotiation between the payer and provider. If a provider is able to negotiate a large enough budget, the provider can more easily ensure their physicians will be protected from any downside risk. NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. The cost of acquiring reinsurance will increase exponentially if a larger segment of the health insurance market engages in risk-based contracts. As a system, NEQCA bears the contractual risk in current global payment agreements, however it does not receive any of the reserves maintained by the insurers (and charged to their accounts) for this risk.

Should more of NEQCA's payers move into risk-based payment agreements, our reinsurance costs would increase significantly and we would face difficulty meeting the capital requirements of increased risk across our entire patient population. Any significant increase in our risk population would require that the risk based capital, currently held by payers, be transferred (at least in part) to providers. At the individual practice level, in order for physicians to be willing to participate in a global risk product, those physicians would need to know they are being made financially whole and that changing practice patterns in a global payment system will leave them, at a minimum, financially neutral when compared to the fee for service model.

An increase in payers negotiating risk-based contracts would also require networks, such as NEQCA, to manage a patient population as a whole, as opposed to managing patients differently depending on which health insurance plan they happen to participate in during a given year. In order to successfully manage a population of patients, providers will need aggregate data on their patient population as a whole, not segmented and filtered by various payers.

3. Please explain and submit supporting documents to show the per member per month cost associated with your efforts to integrate or coordination the medical care that you provide to your patients, including but not limited to costs associated with health information technology, medical management programs, pharmacy programs, practice pattern variation analysis, referral pattern analysis, quality process and outcome measures, and other similar care coordination efforts. In addition, please explain the type of data that you currently utilize, or would like to utilize, to better coordinate and manage the cost and quality of the care that you provide to your patients, including but not limited to claims data, health care provider price data, practice pattern variation analysis, utilization analysis, quality data, or other types of data.

NEQCA's per member per month cost associated with providing the coordinated care in the commercial patient population is approximately $7-$10. Managing the Medicare population requires double this cost (because the Medicare population is older, and has more complex health problems), and because of the high proportion of disabled and medically complicated individuals participating in the Medicaid population, care management may cost even more in the Medicaid population.

These care coordination and care management dollars are used by a network like NEQCA to change the practice behaviors of a physician to effectively manage the cost trend in a patient-centered manner; to provide case managers and other ancillary health providers directly in physician offices, working <u>directly</u> with physician, to more effectively manage the health needs for the chronically ill and most medically complex patients in the practice and thereby reduce costs; and to analyze claims and billing data to determine how to achieve effective patient-centered care and to determine if external factors are impacting the medical expense trend. These programs incorporate behavior health care to address the common behavioral health co-morbidities of the chronically ill population and to address the behaviorally related diagnoses such as diabetes and hypertension.

4. Please describe current competitive dynamics in the Massachusetts health care provider marketplace and how those dynamics impact your organization, including but not limited to the impact on your organization of (i) differentials in rates paid by payers to providers, (ii) provider consolidation, and (iii) physician hiring trends.

In 2010 the Attorney General established that the two main drivers of cost in the healthcare market are utilization and unit cost or price. The Attorney General also established that prices in contracts were arrived at through private negotiations between payers and providers, and not established through any type of transparent process utilizing objective data or quality measures. This reality has created a market of "haves", those with very rich price agreements and "have-nots", those with significantly lower prices. These market inequities, as recently verified by the Division of Health Care Finance and Policy, create inequities in the market which result in an extreme variation in price across the market.

NEQCA has gained a great deal of knowledge from our participation in the Blue Cross Blue Shield Alternative Quality Contract. This version of a global budget payment method is based on historical budgets for providers, plus certain adjustment factors, such as patient acuity. Basing a payment system on historical budgets memorializes current price inequities – i.e., a provider that is low-cost and highly efficient when entering into a contract will only be able to negotiate on a budget that is historically smaller (because that provider's costs were historically lower), whereas a high-cost, inefficient provider will be given a budget that is much larger (because that provider's costs were historically higher).

We have found there are elements in globally paid arrangements that memorialize the price variations between systems and providers. For example, quality payments are based on a percentage of total medical expense, therefore if a provider is more efficient and has a lower total medical expense, that provider also has a lower opportunity for quality payments than if they were a less efficient provider with higher medical expenses. These inequities can be incredibly frustrating to physicians, who see themselves getting paid less for the same services and potentially getting paid less for providing a higher quality of care because their opportunity for reward is lower.

Another significant inequity that exits in the market, whether in fee for service, global payment or other payment arrangement, relates to payment for the infrastructure required to successfully manage a population if patients. Infrastructure cost is another negotiated element in a globally paid contract and providers who have received rich infrastructure budgets for years have the distinct advantage, because they have already been able to use those long-standing higher infrastructure payments to build a robust infrastructure to more easily manage care. A strong percentage of a provider's total medical expense costs can be impacted through that provider's ability to manage care with a robust infrastructure, including electronic medical records, chronic disease registries, reporting systems and integrated programs with care managers necessary to help manage the high-risk high acuity patients.

Other market forces influence and impact the ability of NEQCA's doctors to effectively manage cost. For example, many physicians in a community setting refer their patients for care to his/her local community hospital, however if a physician's community hospital is a high cost facility, then the physician will have a difficult time impacting the cost trend.

The current environment is skewed when market dynamics are manipulated in a manner which drives up cost across the entire system. NEQCA's model operates through contractual affiliations with the physicians in its network – and not through direct ownership of physician practices or direct employment of physicians. This puts NEQCA at a disadvantage when competing against systems that are paid more and distort the market by inflating prices for practices and overvaluing assets. NEQCA's integrated platform providing high quality, low cost care is further eroded when physicians leave the network to join other networks offering higher compensation and then use more expensive facilities.

5. Please explain and submit supporting documents that show whether and how you inform patients when you are reimbursed for the services that you render to them through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only").

NEQCA physicians do not currently notify any of their patients of their status in an alternative payment agreement. This is because the insurance companies are the only entities that have real-time information about an individual patient's benefit design. Many commercial payers give physicians access to real-time eligibility data, which allow for a physician to check whether or not a patient has active health care coverage at the time the patient comes to the office for a visit. But this eligibility data does not include any information about whether or not the patient participates in a limited or tiered network, or whether the patient will have staggeringly different out-of-pocket costs depending on which specialist or hospital the patient is referred to for care. As a result, primary care physicians are making referral recommendations to patients without all of the information he/she needs in order to make a fully informed recommendation.

6. Please explain and submit supporting documents that show how you prevent underutilization of needed services and ensured that less-health patients are treated fairly where your organization is reimbursed through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only").

It is our impression that underutilization is not an issue at this time. NEQCA is committed to accomplishing the three goals of the Triple Aim: improving the health of the population: improving the individual patient's experience of care (access to care, reliability of care, and the quality of the interaction with the system); and reducing the rate of growth of costs. The need to accomplish all three goals simultaneously mitigates against short-sighted or unfair restrictions to access to care for complex patients. For example, patients with diabetes use more healthcare resources because they need care to stay healthy, and are more likely to become ill and need high-cost medical interventions. Our commitment to achieving high quality care and improving patient experience motivates our physicians and health care teams to provide additional care to those patients to assure that the quality of care they get meets standards in our contracts and prevents even more expensive interventions in the future by preventing complications of diabetes. NEQCA physicians are distanced from direct financial incentives of this payment model by NEQCA funds flow policies. NEQCA's policies create significant sharing of financial risk across the network thus no individual physicians is directed effected financially by any individual medical management decision. There are no immediate financial consequences to a NEQCA physician from any individual medical management decision.

Exhibit C: Instructions and AGO Questions for Written Testimony
Instruction 3. Attestation.

I, Jeffrey Lasker, am legally authorized and empowered to represent New England Quality Care Alliance for the purposes of this testimony, and this testimony is signed under pains and penalties of perjury.

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